

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152653 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/15/2015 | |
| NAME OF PROVIDER OR SUPPLIER SUMMIT CITY DIALYSIS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3233 EAST COLISEUM BLVD FORT WAYNE, IN 46805 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| V 000 | <p>INITIAL COMMENTS</p> <p>This was a federal ESRD [CORE] recertification survey.</p> <p>Survey Dates: October 7, 8, 13, 14, and 15, 2015</p> <p>Facility #: 012876</p> <p>CCN #: 152653</p> <p>Survey Census: In-Center: 106 Total: 106</p> <p>Sample: RR: 10 Total: 10</p> <p>Summit City Dialysis is in compliance with the Conditions for Coverage 42 CFR Part 494 for End-Stage Renal Disease Facilities.</p> <p>QR: KH, R.N.</p> | | | V 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.